pt/acupuncture new client form

Name ____ Date ____________

Date of Birth____

Address ____

City ____________________________ State __________ Zip ___________

Home Phone _______________________ Work Phone ____________________

Email ____

Emergency Contact _____________________________ Phone ______________

Referring Physician: ____

Primary Care Physician ____

Please describe or list your reason(s) for seeking treatment:______________________

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Do you have any other medical conditions not listed above?______________________

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How did you hear about Inspire Health? ______________________________

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I acknowledge that I am responsible for all fees associated to the treatment I receive. I am aware that Inspire Health does not bill third party payers (insurance companies) for payment.

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Signature Date

107 West Paces Ferry Rd, Suite 200 Atlanta, GA 30305 | ph 404.605.9091 • fax 404.605.7178